The privatization of the National Health Service

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THE FOUNDING VALUES OF THE NATIONAL HEALTH SERVICE

The National Health Service (NHS) was designed to reflect a distinctive set of political and ethical values about the nature of social justice in a nation emerging from war[1]. They were values about equity and fairness, and they were directed towards the creation of a society in which everyone, rich and poor alike, could contribute to and share in the prosperity of the nation. Equity found expression in the NHS in the belief that access to good quality care should be equally available to all in similar need, wherever they lived or whatever their income. Fairness was reflected in the belief that the service should be funded from progressive taxation and freely available at the time of use.

For these values to be realized, the NHS had to be both funded and provided through the public sector. Public funding was necessary because it was only through the taxation system that people could pay for the service in proportion to their income; and, in the political climate of the post-war years, the public provision of services was seen as the obvious way of ensuring people's access to care on the basis of their need rather than their ability to pay. Funding and providing were two sides of the same coin, inseparably linked through the public sector.

A parallel market in health care existed in the UK from the earliest days of the NHS, much though the first Minister of Health, Aneurin Bevan, would have wished to avoid it[2]. But Bevan and his immediate successors in the Ministry of Health tried to maintain a clear distinction between what was public and what was private. The private sector existed, it was a fact of life, albeit a regrettable one; but it should not have any major impact on the publicly provided NHS. It was an arrangement that worked so well for the first 30 years of the service that the Royal Commission on the NHS, reporting in 1979, was able to say approvingly that '. . . it is clear that the private sector is too small to make a significant impact on the NHS, except locally and temporarily'[3].

The Royal Commission Report was, however, almost the last major reaffirmation of the view that public is better than private and that the private sector could be tolerated only as long as it did not destabilize the NHS. In May 1979, 3 months before the Commission reported, Mrs (now Lady) Thatcher became Prime Minister, and under her political leadership the welfare state, including the NHS, was to change out of all recognition[4].

THE ORIGINS OF THE REFORMS EFFECTED BY THE THATCHER GOVERNMENTS

The problems of the welfare state that the Thatcher governments sought to address were complex and long standing. In part, the solutions that were tried were ideologically driven: Mrs Thatcher made a virtue of her claim to be a 'conviction' politician, and among her most fundamental convictions was the need to redraw the traditional lines of responsibility between public and private domains[5]. Yet the reforms were never a matter simply of ideology: there were also immense operational problems facing the welfare state in the early 1980s that had to be tackled. The so-called 'winter of discontent' in 1978–1979 had raised the public's awareness of the unfriendly nature of many services, their inconsistent reliability and their sometimes shadowy accountability to the people they served. At the same time central government was struggling to maintain its traditional responsibility to Parliament for the day-to-day operations of the public services, particularly the NHS, in the face of their expanding scale and complexity[6].

Against a gloomy economic background of inflation and stagnation, recognition was also growing of the widening gap between needs and resources, and increasingly urgent questions were asked about the continuing feasibility of a universal and comprehensive health care system paid for by taxpayers and free at the point of use. Following the dramatic increase in world oil prices in 1973 the language of discourse in the NHS began to change, and as the 1970s unfolded there was progressively less talk of meeting people's needs and correspondingly more talk of budgets, efficiency savings and rationing.

So here, by the early 1980s, was a powerful cocktail of forces: an incipient collapse of the traditional ways of providing public services and a strong 'conviction' politician, with a large majority in the House of Commons and very clear ideas about how she wanted to use it. And the public sector services are still reverberating from the explosion caused by the conjunction of these forces.

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THE STRUCTURAL BASIS OF CHANGE

One of the distinctive leitmotifs of the Thatcher years was that of market competition. A central part of Mrs Thatcher's diagnosis of the ills of the public services in general, and the NHS in particular, was precisely that the absence of competitive market forces had led to high production costs, variable quality, and little choice for the users of the service. Her remedy consisted of an iterative set of radical treatments.

The first step was the creation of a quasi-market structure in the NHS by separating out those who purchase (or commission) services from those who provide (or sell) them—the celebrated purchaser–provider split that lies at the heart of the internal NHS market[7]. An innovative feature of this step, which is likely to have increasingly important repercussions for the pattern of services available in different localities, was the endowment of purchasing capacity on those general practices who chose to assume responsibility for their own budgets. The second step was the injection into the market of a dose of managed competition by enabling the purchasers to contract with the providers of their choice. The third step, which was achieved through a series of innovations that would have been unimaginable to those nurtured on the post-war tradition of collective public action, was to begin to shift the functions of both providing and purchasing away from the public sector towards the private sector.

SHIFTING THE PROVISION OF CARE FROM PUBLIC TO PRIVATE DOMAINS

First, new policies were introduced to shift some of the provision of health care from public to private providers while retaining public control of the funding. Three policies were particularly important. The first was the introduction of competitive tendering or, as it later came to be called, market testing[8]. Even from the earliest days of the NHS, health authorities had contracted some of their services out to private and charitable agencies, including some specialist forms of medical care. But these relatively low-key arrangements were given a major new twist in the 1980s with the government's demand that more of the services that health authorities had traditionally provided in-house should be tested in competition with private contractors.

The first services to be market tested were the cleaning, catering and laundry facilities in NHS hospitals; and they were followed later by other non-clinical services like transport, computing and management. As the programme developed, services were increasingly provided not by the NHS staff but by private contractors[9]; and it was the logical extension of the principle of market testing that provided the framework for the internal NHS market in 1991.

Stripped of its complexities, the market can be seen as an arrangement in which public sector purchasers (health authorities and fund-holding general practices) contract all their requirements for hospital and community health services through market testing, including not only support services like cleaning, catering, laundry and transport, but also the full range of clinical services[10]. In reality, the overwhelming majority of contracts are placed with NHS hospital trusts; but an increasing number of contracts, including those placed by the fund-holding general practices, are now being negotiated with private hospitals, nursing homes and laboratories, resulting in a growing stream of public money that is spent in the private sector[11].

A third policy initiative to shift the balance of service provision from the public to the private sector has been the gradual withdrawal of the NHS from the long-term social and nursing care of old people, creating a vacuum that has been filled by the private residential market. The process began in the early 1980s with changes allowing social security payments to be used to support the care of elderly people in private homes. As the numbers of elderly long-stay

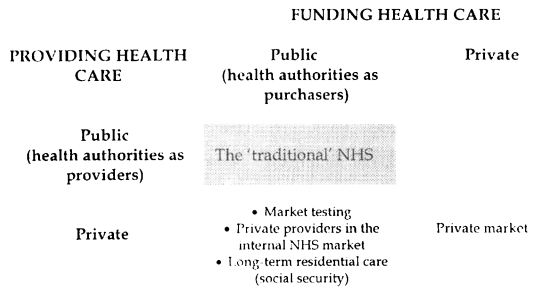

Figure 1 **The shift from public to private provision of health services**

beds in NHS hospitals diminished, so the numbers of places in private residential homes (funded from the public social security system) expanded, further transferring the burden of service provision away from the public sector towards the private.

The effect of market testing, the internal market, and the growth of long-term private residential care can be set against the 'traditional' NHS as shown in Figure 1.

SHIFTING THE FUNDING OF CARE: PRIVATE MONEY FOR PRIVATE PROVIDERS

The next step in the Thatcher governments' programme of transition was to shift some of the funding services from public to private sources. The extra resources that have been attracted into the system have gone partly to private providers (the bottom right cell in Figure 1) and partly to public providers (the top right cell in Figure 1).

Taking the former first, three measures have been particularly instrumental in stimulating the flow of private money to private providers. For the most part, the money has come from individual consumers, representing an

increase in the proportion of disposable income that people are now spending on health care.

First, the private purchase of privately provided acute hospital care was stimulated through a number of measures including extended tax rebates to those with private health insurance and a liberalization of the regulations allowing doctors to undertake private work without jeopardizing their NHS salaries. In 1982 tax exemptions were introduced for occupational health insurance premiums for lower paid workers, and further regulations in 1990 allowed older people to offset the cost of private health insurance against tax[12]. Changes to the consultant contract in 1979 enabled hospital doctors to undertake a limited amount of private practice while remaining in full-time employment in the NHS[13]. These and other measures ensured a sharp increase in the number of people covered by private medical insurance throughout the 1980s; but the combined effects of economic recession and the rapidly rising costs of premiums have reversed the trend in the 1990s[14].

Secondly, the development of the private sector was further stimulated by the changes occurring in the national policy for community care: although the cost of private residential care for elderly people was borne initially by the social security budget, it was switched in 1993 to the local authorities. Thereafter, more of the costs began to fall directly on the elderly residents themselves, subject to a test of their capital assets, effectively transferring many of them from a publicly funded programme to a privately funded means-tested programme[15].

Another measure that stimulated the shift from public to personal spending has occurred in the areas of ophthalmology, dentistry and pharmacy. The withdrawal of sight testing from the NHS in 1989 and the refusal of general dental practitioners in many parts of the country to accept new NHS patients have required people to spend more of their own money on the private care of their eyes and teeth; and the trend towards the deregulation of drugs, allowing patients to purchase many preparations which had formerly been available only on prescription, has caused people to pay over-the-counter prices for medicines which formerly might have been prescribed without charge.

The effect of these measures (the encouragement of private practice, the changes to the community care policy, and the reductions in state funding for ophthalmology, dentistry and pharmacy) can be set against the 'traditional' NHS as shown in Figure 2.

SHIFTING THE FUNDING OF CARE: PRIVATE MONEY FOR PUBLIC PROVIDERS

The drive of the Thatcher governments to increase the flow of private funding extended to ways of attracting private resources towards public as well as private providers (the

	FUNDING HEALTH CARE	
PROVIDING HEALTH CARE	Public (health authorities as purchasers)	Private
Public (health authorities as providers)	The 'traditional' NHS	
Private	• Market testing • Private providers in the internal NHS market • Long-term residential care (social security)	• Private health insurance • Long-term residential care (means-tested) • Private spending on drugs and on dental and ophthalmic care

Figure 2 **The shift from public to private funding of health services**

top right cell in Figure 2). The resources flowing through this conduit have come from corporations as well as individuals.

An early example was the introduction of income generation schemes. The 1988 *Health and Medicines Act* gave health authorities the legal right to sell goods, services, land and anything else at commercially appropriate rates. Such schemes have not consistently raised the amount of money that was originally expected of them[16]; but they have been symbolically significant in further breaking down the barriers between public and private.

A second example of the attempts made by the Thatcher governments to attract money from private corporations is found in the structure of the internal market. Although the NHS trusts earn by far the larger share of their income from contracts with the public sector purchasers, many are now also developing portfolios of contracts with private insurance companies, enabling them to admit not only NHS patients funded by public money but also private patients funded by the commercial insurance companies. This was always regarded as a potent incentive for hospitals to choose trust status, and some have even reportedly attempted to develop their market penetration by issuing their own private insurance policies[17].

An example of the attraction of private corporate funding into the NHS is the Private Finance Initiative (PFI), introduced in 1992. The PFI applies across the whole of the public sector, not just the NHS, though the service has so far been the largest beneficiary of the scheme[18]. Instead of using public money to fund public sector capital development projects, the PFI aims to attract private venture capital to build prisons, houses, hospitals, railways, roads, and so forth. The facilities are then leased back to the public sector operators (such as the NHS trusts in the case of hospitals), often with long-term guarantees that protect the investment. To date, projects to the value of about £5 billion have been agreed, including some £450 million for hospital building.

The effect of income generation, the admission of private patients to NHS trust hospitals, and the PFI can be set against the 'traditional' NHS as shown in Figure 3.

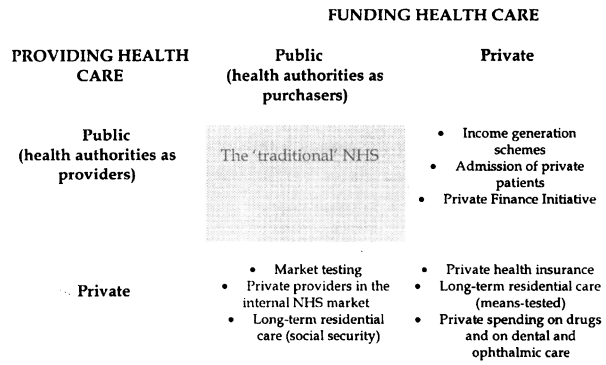

Figure 3 **The shift from public to corporate funding of health services**

AN END TO THE NHS?

It is plain from Figure 3 that health care in the UK had, by 1996, moved a long way from its post-war position as a publicly funded and publicly provided service. It could scarcely be regarded as a planned or coherent programme of change for it represented the summation of many different policy initiatives, taken at different times, with different purposes in mind. It did, however, broadly reflect a consistent set of political beliefs and aspirations about the public sector services and their proper relationships with private economic activity, and in the eyes of many it constituted a planned assault on the NHS and the values that it had traditionally espoused[19].

The question forced by this programme of change is whether it matters for the goals and values of the NHS. Does it matter that health care in the UK is now provided less by public sector services and more by private sector entrepreneurs? Does it matter that traditional public sources of funding for the NHS are now augmented by greater inflows of private money?

The conventional response of those who favour the new mixed economy of health is that, far from undermining the traditional values of the NHS, the emerging combinations of public and private will positively enhance them by enabling the service to deliver more care from each pound spent on it. If the internal NHS market, together with its trappings of competitive tendering, income generation schemes and private financing, can deliver a more efficient pattern of care than the former system of centrally allocated budgets to uncompetitive providers, then it is of secondary importance whether those who actually produce the services are working in the public or the private domain.

What matters more from this perspective is the funding and commissioning of services. If funding continues to be provided largely by the state, and if commissioning remains in the control of public-sector agencies like the health authorities and fund-holding general practices, then the mechanisms for ensuring the continuation of the traditional values will remain intact. Those who commission services from their allocation of public funds will continue to be the guardians of the public interest, acting in ways that will meet the health care needs of their local populations while paying due attention to issues of accessibility, appropriateness, equity, and so forth.

VOICES OF SCEPTICISM

Yet there are those who regard any further moves along the road towards a competitive private market with misgiving. They are sceptical of the claim for greater productive efficiency in the private than the public health care sector, pointing to countries such as the USA where administrative costs can be very high and the competitive relationship between hospitals can lead to the duplication and under-utilization of expensive facilities[20].

The sceptics also point to the fact that much of the private capital now flowing into the NHS through the PFI is an alternative rather than an addition to public capital investment. Through the PFI, central government is effectively borrowing now and paying later to develop the capital stock of the NHS. Not only is this saddling the service with substantial long-term commitments through the leasing arrangements into which the NHS trusts are entering, it is also increasing the number of trust hospitals that are owned and managed by the private sector. As more hospitals are not only designed, built and financed but also managed through the PFI, the long-term ability of the NHS trusts to resist the logic of the capital markets must come into doubt.

WHERE MAY THE PROCESS END?

Although the policies reviewed in this paper originated largely as discrete attempts to advance the efficiency of the NHS, they may now have coalesced to a point at which they begin to acquire a developmental momentum of their own.

The NHS may find it increasingly difficult to resist the pressures for further change not only in its relationship with the private sector but also in its rationale: it may be unable to withstand a process that would transform it into a residual public service for those who cannot or will not make their own private arrangements for their health care.

The end-point of such a process might be the creation of a private market that is publicly regulated. The model would not be unique to health care: public regulatory mechanisms have been set up in several other markets in the UK where services and utilities have been sold to the private sector, including gas, water, electricity and so forth. The early experiences of public regulation are insufficient to predict the likely effectiveness of a regulator in a private health care market, but it is difficult to see how, in such circumstances, the traditional values of the NHS could be substantially preserved. Public and private interests do not necessarily

coincide, and public values (such as, in the case of the NHS, those of equity and fairness) will only be pursued in competitive markets if they are seen to have commercial value.

In principle, a democratic society should offer its citizens the chance to choose the direction in which a major enterprise like health care should move. In reality, the complexity of the enterprise and the tendency of policies to develop a momentum of their own may place any such choice beyond the bounds of feasibility. That the UK may eventually find itself having abandoned the NHS in favour of a publicly regulated but privately driven market may surprise those who supposedly control the processes of administrative change as much as those whose quality of life is dependent upon them.

REFERENCES

1 Titmuss R. *Problems of Social Policy*. London: HMSO & Longman, 1950

2 Bevan A. *In Place of Fear*. London: MacGibbon & Kee, 1961

3 Royal Commission on the National Health Service, *Report, Cmnd 7615, para 18.41*. London: HMSO, 1979.

4 Johnson N. *Reconstructing the Welfare State*. London: Harvester Wheatsheaf, 1990

5 Savage SP, Robins L, eds. *Public Policy under Thatcher*. London: Macmillan, 1993

6 Gray A, Jenkins WIJ. Public management and the National Health Service. In: Glynn JJ, Perkins DA, eds. *Managing Health Care*. London: WB Saunders, 1995

7 Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for Patients, Cmnd 555*. London: HMSO, 1989.

8 Key T. Contracting out ancillary services. In: Maxwell R, ed. *Reshaping the National Health Service*. New Brunswick: Transaction Books, 1988

9 Sheaff R. *Marketing for Health Services*. Buckingham: Open University Press, 1991

10 Butler JR. *Patients, Policies and Politics*. Buckingham: Open University Press, 1992

11 NHS Executive. *Market Testing in the NHS*. Leeds: National Health Service Executive, 1995: EL(95)29

12 Allsop J. *Health Policy and the NHS Towards 2000*. London: Longman, 1995

13 Yates J. *Private Eye, Heart and Hip*. Edinburgh: Churchill Livingstone, 1995

14 Suzman M. Healthy prospects entice participants. *Financial Times* 1996; **22** (July):11

15 Lelliott P, Sims A, Wing J. Who pays for community care? The same old question. *BMJ* 1993; **307**: 991–4

16 Little S. Experts fear bleak future for income generation. *Hlth Serv J* 1990; **100**: 829

17 Dean M. Further doubts raised over UK's private finance initiative. *Lancet* 1996; **347**: 1253

18 Ham C. Profiting from the NHS. *BMJ* 1995; **310**: 415–16

19 Moore W. Radical surgery. *Hlth Matters* 1996; **24**: 12–13

20 Dixon J. US health care I: The access problem. *BMJ* 1992; **305**: 817–19